



Controversies

Safety preempted: When EMTALA and restraining orders collide

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A patient has been stalking Dr. Smith, an emergency physician at St. Mary's Hospital, for months. His stalking behavior has included frequent phone calls and e-mails. The patient has come to the emergency department at Saint Mary's during shifts worked by Dr. Smith several times. He has been in the emergency department 15 times in the last six months for vague complaints. Extensive medical work-ups have been negative. The patient frequently leaves against medical advice. He has been seen by multiple consultants including psychiatry, who diagnosed him with malingering and gave no other psychiatric diagnosis. When seen by Dr. Smith, he is frequently verbally aggressive and threatening. At the last ED visit, the patient assaulted Dr. Smith. Given the behavior, Dr. Smith obtained a restraining order against the patient, who continues to regularly go to the emergency department and continues to make threatening statements to staff members about Dr. Smith. Should Dr. Smith have to treat this patient?

The Emergency Medical Treatment and Active Labor Act (EMTALA) passed in 1986 with the intention of improving disparities in access to care by requiring US hospitals to accept patients regardless of their ability to pay [1].

According to EMTALA, "the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department," to anyone seeking medical care [2].

EMTALA requires that an emergency department provide all patients a "medical screening exam" (MSE) and ensure patient stability before discharge or transfer.

In a single coverage emergency department, this demonstrates a significant dilemma if the physician on duty holds a restraining order against a presenting patient. Though the court states this patient cannot interact with this physician, the physician has a duty via EMTALA to assess the patient for a medical emergency and stability. Currently, EMTALA, a federal law, would supersede a restraining order, which are typically issued by the state courts.

Any situation that results in a physician refusing care to a patient raises challenging ethical issues. However, except in a few narrowly defined areas, most notably the rights of prison inmates, there is no constitutional right to receive healthcare [3]. While ethical norms and good public policy argue for providing healthcare to patients in emergency circumstances, rare circumstances may arise that merit an exception to this general rule.

In order to provide optimal care to each of their patients, physicians need to be able to practice their craft with basic protections from violence and harassment. Violence against emergency personnel presents a serious and increasing problem. In 2018, the American College of Emergency Physicians (ACEP) polled over 3500 emergency physicians (EPs) and found nearly half had been assaulted while at work, more than one quarter had been injured, and 83% have been threatened. 97% of assailants were emergency department patients [4]. A study of EPs in Michigan found that the rate of physical assault against doctors has increased in the past decade and that physicians are increasingly concerned about becoming victims of violence [5]. According to the National Institute for Occupational Safety and Health, healthcare workers are an increased risk for workplace violence [6]. Multiple states have specific laws and protections against assaulting healthcare workers.

State courts generally issue restraining orders only in extreme cases. If a provider goes to the considerable lengths required to obtain such an order against a potential patient and the courts agree that such a danger exists, a mechanism ought to be developed to allow the provider to refuse all interactions with this would-be patient. As of 2014, over 1.4 million restraining orders had been entered into federal databases [7]. While it is impossible to know how many of these are taken out by physicians against patients, it seems likely to be a very small percentage.

While such cases will likely prove uncommon, and generally derive from conflicts that arise through professional interactions, there will also be a subset of cases in which providers are victims of violence or harassment by individuals they have not seen in a professional setting who then choose to seek care in their emergency departments as a means of further targeting them. These potential victims are in particular need of additional protections.

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EMTALA aspires to limit discrimination based on ability to pay for medical services and has become the de facto health care policy for the uninsured [8]. However, this noble aim likely did not intend to force a physician to work with a patient who has volitionally engaged in repeated aggressive or violent behavior towards a provider and who threatens to do so again.

The California Supreme Court, in *Payton v. Weaver* (1982), has directly addressed the issue of terminating a patient due to disruptive behavior. In this case, Dr. Weaver refused to treat a patient at his dialysis facility due to “persistent uncooperative and antisocial behavior over more than three years” [9]. The court sided in favor of Dr. Weaver, arguing that the patient’s conduct was so detrimental that it infringed upon the rights and privileges of other patients.

In the majority opinion, the Court stated “it is unlikely that the legislature intended to impose upon whatever health care facility such a patient chooses the unqualified obligation to provide continuing preventative care.” However, the Court suggested should the patient present to an emergency department requiring immediate life-saving treatment, it is likely required to provide the emergent care and that hospitals “should not be permitted to withhold its services arbitrarily, or without reasonable cause.”

We believe that the principles outlined in *Payton v. Weaver* should be extended—under vary narrow circumstances—to the emergency setting. Patient conduct rising to the level of requiring a restraining order infringes on the rights of the physician to feel safe and limits her ability to provide quality care to other patients in the hospital. Refusing care in this situation, while a difficult decision, would not be applied “arbitrarily” or “without reasonable cause.” A physician who has a restraining order against a patient should have the right, at her discretion, to refuse to provide a medical screening exam, as even a medical screening exam could involve quite a lengthy interaction, as in the case of significant chest pain, for example. Alternative mechanisms should be established to ensure treatment for such a patient.

This approach does not mean that such patients will likely go without care at all. Ideally, a colleague or separate part of the emergency department will be able to manage a patient with a history of aggression towards a specific provider. However, in emergency departments with a single covering provider, the medical system should honor the court issued restraining order and divert the patient to another facility.

This rare situation would not be particularly burdensome or unique. Diversion is a common, temporary technique used to assure patients can get emergency treatment. In 2011, two out of every three hospitals diverted ambulances to other facilities when they could no longer accept specific types of patients due to resources [10]. Diverting one patient to protect the well-being of a physician would therefore be something relatively simple and in line with general hospital practices. (The approach would also allow for the fire captain or EMS consulting physician to overrule the diversion order for such a patient, just like they can do more generally, in extremely rare cases of severe trauma or cardiac arrest where a delay of a few minutes may prove life threatening.) Ambulance services could be provided in advance with the names of patients to be diverted away from specific hospitals so as to minimize delays in acute care.

We acknowledge diversion would not address all cases, such as walk in patients, and would be a difficult solution in very remote settings. Balance must be achieved between protecting staff and ensuring care. There may be logistical and practical limitations in some cases. However, there are possible solutions. For example, a patient’s insurance coverage could be restricted to hospitals where no restraining order exists, deterring such patients from walking in off the street. Such an approach would protect the physician and allow her to provide optimal care in her department, likely minimizing the burden on the medical system.

EMTALA helps to limit treatment disparities in emergent situation but can have the surely unintended consequence of forcing a physician to provide care to someone against whom they have obtained a restraining order. The number of physicians with such orders against patients may currently be minimal. However, we suspect that hospital staff would be more likely to obtain a restraining order against assaultive or harassing patients, if they know there is utility in going through the significant effort to have one granted.

Practical solutions such as patient diversion exist to solve this problem. Congress ought to carve out a narrow exception to EMTALA that allows for deference to restraining orders from state courts. Allowing emergency physicians to refuse medical screening exam in these narrow situations would protect the rights of physicians, allow them to practice in a safe environment, and ultimately benefit all patients treated in the emergency setting.

Declaration of Competing Interest

The authors have no conflicts of interest to declare.

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